with the National Park Service, and he will bring with him our friendship and respect.

On behalf of myself and Jim Zoia of my staff, we wish Joe and Jayne Kennedy the very best.

HEALTH CARE ANTIFRAUD AND ABUSE INITIATIVE OF 1995

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 22, 1995

Mr. STARK. Mr. Speaker, today I am introducing H.R. 1912, the Health Care Fraud Prevention and Paperwork Reduction Act. This bill establishes an effective national program to control fraud, waste, and abuse in our health care system.

When Willie Sutton was asked why he robbed banks, he responded: ''Because that's where the money is.'' Today's criminals continue to be attracted to where the money is—in health care. State officials in Florida report that drug traffickers are changing professions because the money is bigger in health care fraud and the risk is less.

Fraudulent activities involve both Government programs and private payers. Federal outlays for Medicare along totaled $162.5 billion in fiscal year 1994, and are expected to exceed $177 billion in 1995 and $198 billion in 1996. GAO estimates that fraud and abuse in the health care industry accounts for an estimated 10 percent of our yearly private and public expenditures. In 1994, this would have approached $94 billion. That amounts to approximately $258 million a day or $11 million every single hour.

The bill would establish an all-payer health care fraud and abuse program, coordinated by the Office of the Inspector General [OIG] of the Department of Health and Human Services. In fiscal year 1994, the OIG generated savings, fines, restitutions, penalties, and receivables of over $8 billion. This represents $80 in savings for every Federal dollar invested in their office, or $6.4 million in savings per OIG employee.

H.R. 1912 would extend Medicare and Medicaid's proven enforcement remedies of civil monetary penalties and criminal penalties to private payers. The policies are proven and represent 25 years of experience in fighting fraud and abuse under Medicare. The bill is an improved version of the antifraud measures included in last year's health reform legislation.

Equally important as preventing and detecting fraud and abuse in the health care system is the deletion of waste. Forms, other paperwork, and burdensome administrative requirements increase the patient costs and frustrate the provider.

The bill would improve the efficiency and effectiveness of the health care system by establishing standards and requirements for electronic transmission of certain health information. H.R. 1912 would reduce the administrative cost of the current system and make health insurance documents easier for patients and providers to understand. A uniform health claims card would be distributed to each beneficiary of a health plan, and all medical records and reporting would be transmitted using a uniform electronic format.

Hearing after hearing has outlined the heavy fraud, waste, and abuse in health care, yet little is done to remedy the problem. Ample evidence exists to show that this activity is costing us millions of wasted dollars each day. We must not wait to enact tougher penalties and enforcement procedures for health care fraud nor should we wait to simplify the administrative processes associated with our health care system. The wasted dollars are far too valuable. This bill should be passed this year.

The following is a summary of the bill:

ANTI-FRAUD AND ABUSE INITIATIVE OF 1995

TITLE: FRAUD AND ABUSE

Subtitle A: Amendments to anti-fraud and abuse provisions applicable to Medicare, Medicaid, and State health care programs

I. Amendments to anti-kickback statutory provisions

A. An intermediate civil monetary penalty of up to $50,000 would be established for anti-kickback violations

B. The current criminal fine would be increased to no more than $50,000

II. Amendments to exceptions to anti-kickback statutory provisions

A. Current exception for discounts would be modified to prevent providers from giving discounts in the form of a cash payment

B. Current exception for bona fide employment relationships would be modified to require that any remuneration be consistent with fair market value, and not be determined in a manner that takes into account the volume or value of any referral

C. Current exception for waiver of coinsurance would be modified to allow for such arrangements if—

(1) A waiver or reduction of coinsurance is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply; or

(a) The person determines in good faith that the individual is indigent, or

(b) The person fails to collect coinsurance or deductible amounts after making reasonable efforts, and

D. An exception would be provided for certain arrangements where providers are paid wholly on a capitated basis

III. Amendments to civil monetary penalty statutory provisions

A. A civil monetary penalty would be established for the following improper conduct:

(1) Offering inducements to individuals to receive from a particular provider an item or service

(2) Engaging in a practice which has the effect of limiting or discouraging the utilization of health care services

(3) Substantially fails to cooperate with a quality assurance program or a utilization review activity

(4) Substantially fails to provide or authorize medically necessary items or services that are required to be provided under the health plan, if the failure has adversely affected (or had a substantial likelihood of adversely affecting) the individuals

B. Civil monetary penalties would be increased to no more than $10,000 for each false or improper item or service

C. The assessment would be increased to three times the amount claimed and interest shall accrue on the penalties and assessments after a final decision

D. If within one year the Attorney General does not initiate a criminal or civil action the Secretary could initiate a civil monetary penalty proceeding

IV. Private Right of Action

A. Any person that suffers harm as a result of any activity of an individual or entity which makes the individual or entity subject to a civil monetary penalty may bring a civil action

V. Amendments to exclusionary provisions in fraud and abuse program

A. The Secretary would have the additional authority to exclude individuals and entities based on felony convictions relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care item or service

B. The Secretary's current discretionary exclusion authority would be extended to permit the Secretary to exclude individuals who retain an ownership or control interest in a sanctioned entity

C. Minimum period of exclusion for certain violations already specified in statute would be established

VI. Amendments to quality of care sanctions

A. Practitioners or persons who violate quality of care obligations as determined by the Peer Review Organization would be subject to a civil monetary penalty of not more than $10,000

B. The additional requirement that the practitioner be shown to be ''unwilling or unable'' to meet PRO quality of care obligations before the Secretary may exclude the individual from participating in Medicare would be deleted.

VII. Revision of criminal penalties

A. For providers who violate specified fraud and abuse provisions, penalties would include fines, treble damages, and imprisonment

VIII. Amendments to criminal and civil laws

A. A criminal violation for health care fraud would be created for the following crimes

(1) Whoever knowingly executes a scheme to defraud any health plan or person, in connection with the delivery of or payment for health care items or services

(2) Penalties would include a fine and a prison term of not more than 5 years

B. Forfeitures for violations of fraud statutes

(1) If the court determines that a Federal health care offense is of a type that poses serious threat to a person's health, or has significant detrimental impact on the health care system, the court could order the person to forfeit property used in or derived from proceeds from the offense and is of value proportionate to the offense

Subtitle B: Establishment of all-payer health care fraud and abuse control program

I. The Secretary of Health and Human Services (acting through the Inspector General of HHS) and the Attorney General would establish and coordinate an all-payer national health care fraud and abuse control program

II. The Attorney General and Inspector General would be authorized to conduct investigations, audits, evaluations and inspections relating to the delivery of and payment for health care and to have access to all records available to health plans relating to the program

III. Coordination with law enforcement agencies and third party insurers

A. The Secretary and the Attorney General would be required to consult with, and arrange for the sharing of resource data with State law enforcement agencies, State Medicaid fraud control units, State agencies responsible for the licensing and certification of health care providers, health plans, and public and private third party insurers

IV. General provisions regarding all-payer fraud and abuse program

A. All health plans, providers, and others would be required to cooperate with the national fraud control program and to provide

such information as is necessary for the investigation of fraud and abuse

(1) Procedures would be established to assure the confidentiality of the information required by the national fraud and abuse program and the privacy of individuals receiving health care services

B. Health plans and providers would be required to disclose information that the Secretary deems appropriate, including information relating to the ownership, control and management of a health care entity

IV. Establishment of fraud and abuse account

A. Civil money penalties, fines, forfeitures and damages assessed in criminal, civil or administrative health care cases, along with any gifts and bequests would be deposited in an ''All Payer Health Care Fraud and Abuse Control account''

B. The assets in the Account would be used, in addition to such appropriated amounts, to meet the operating costs of the national health care fraud control program

Subtitle C: Application of fraud and abuse authorities under the Social Security Act to other payers

I. Application of civil monetary statutory penalties to all payers

A. The provisions under the Medicare and Medicaid programs which provide for civil monetary penalties for specified fraud and abuse violations (as amended by this Act) would apply to similar violations with respect to all payers

B. The following activity would be prohibited and subject to a civil monetary penalty not to exceed $10,000:

(1) Expelling or refusing to re-enroll an individual in violation of federal standards for health plans or State law

(2) Engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment in a health plan on the basis of a medical condition

(3) Engaging in any practice to induce enrollment in a health plan through representations which the person knows or should know are false

Subtitle D: Advisory opinions on kickbacks and self-referral

I. Issuance of Advisory Opinions

A. The Secretary would require an individual requesting an advisory opinion to pay a fee equal to the costs incurred by the Secretary to issue the opinion.

Subtitle E: Preemption of State corporate practice laws

I. Preemption of State Laws Prohibiting Corporate Practice of Medicine

A. No provision of State or local law would apply that prohibits a corporation from practicing medicine.

TITLE II: INFORMATION SYSTEMS AND ADMINISTRATIVE SIMPLIFICATION

I. Uniform health claims card

A. Each beneficiary of a health benefit plan, including Medicare, would be issued a uniform health claims card

B. Each card would include a uniform health claims identification number which would be the Social Security number of the beneficiary

C. The card would be in a form similar to that of a credit card and would have information encoded in electronic form

II. Requirement for entitlement verification systems

A. The Secretary would provide for an electronic system for the verification of an individual's enrollment in a health plan, including Medicare and entitlement to benefits

B. The Secretary would establish standards respecting the requirements for certification of entitlement verification systems

(1) The system would be required to be able to coordinate benefit information among health plans and Medicare

(2) The system would also be required to accept inquiries from health care providers and health benefit plans electronically through the use of electronic card readers, touch-tone telephones, or computer modems

(3) Health benefit plans that fail to provide for an electronic verification system would be subject to civil monetary penalties

III. Uniform claims and electronic claims data set

(A) All claims submitted by providers would be transmitted using a uniform electronic format to be developed by the Secretary

(B) The Secretary would develop a single, uniform coding system for procedures and diagnoses

(C) The Secretary would provide for a unique identifier code for each health service provider and health plan

(D) Health service providers and health plans that fail to submit a claim for payment in a form and manner consistent with the standards would be subject to civil monetary penalties

(E) All claims for clinical lab tests would be submitted directly by the person or entity that performed the test.

IV. Electronic medical records and reporting

(A) The Secretary would promulgate standards for hospitals concerning electronic medical records

(B) As a condition of Medicare participation each hospital would be required to maintain hospital clinical data in electronic form in accordance with these standards

(C) State quill pen laws that require medical or health information to be maintained in written form would be pre-empted

V. Uniform hospital cost reporting

(A) Each hospital would be required to report information on costs to the Secretary in a uniform manner consistent with standards established by the Secretary

DELAURO HONORS DOROTHY BROWN OF STRATFORD UPON HER RETIREMENT

HON. ROSA L. DeLAURO

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 22 1995

Ms. DELAURO. Mr. Speaker, on Friday, June 23, 1995, the town of Stratford will pay tribute to Dorothy Irene Brown in honor of her retirement. After 48 years of exemplary service to the residents of Stratford, Dorothy Brown will be retiring from the position of town purchasing agent.

Dorothy Brown began her career with the town of Stratford in 1947. Since then, she has worked tirelessly to provide the highest standard of service to the town's citizens. Indeed, her dedication and attention to detail have become legendary. Among her many achievements are the implementation of numerous cost-saving measures that have greatly benefited the town of Stratford and its residents. Dorothy is an extremely conscientious and dedicated employee and will be sorely missed by her colleagues.

Dorothy has also served with distinction as president of the Stratford Supervisors Union, and chairwoman of the Stratford employees pension fund. Her strong and insightful leadership skills have earned her enormous respect among her colleagues. For almost half a century she has been the epitome of a public servant.

Mr. Speaker, I am proud to salute Dorothy Brown for a lifetime of service to her community. It is people like Dorothy who make local government work for its citizens, by addressing their needs on a personal level. The contributions of these exemplary public servants should not be overlooked. Their hard work and commitment are the cornerstone of strong and effective local government. Individuals such as Dorothy Brown deserve our strong support and admiration.

I extend my warmest congratulations to Dorothy on this well-deserved tribute, and commend her for 48 years of distinguished work. I wish her many years of good health and happiness in her retirement.

TRIBUTE TO MINA AND JORDAN RUSH

HON. HENRY A. WAXMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 22, 1995

Mr. WAXMAN. Mr. Speaker, please join me in saluting Mina and Jordan Rush, who will receive the service award for their vision of the future at the 47th Annual Tribute Dinner of B'nai David-Judea Congregation on June 25, 1995.

Mina Rush has served B'nai David-Judea Congregation in numerous capacities for many years. She has been a member of the board of directors, membership chairman, and co-chairman of the annual banquet.

Mina Rush has always generously and selflessly devoted herself to worthwhile causes. She has served the State of Israel and cooperated with the Israel Defense Forces in her work with the Volunteers for Israel. She also led the recent Kiev emergency relief project that provided enormous quantities of food for a starving community.

Jordan Rush has had a distinguished career in entertainment as a producer, director, and actor. He served in these roles in ''The Mirror,'' which was honored at the Southwest Film Festival. As a humanitarian, he has chaired Volunteers for Israel and Adopt a Soviet Family, a program of the Jewish Federation.

Proud parents of Tzvia, Atara, and Harel, the Rushes have always been concerned with the future of our Jewish youth. Their entire family worships regularly at B'nai David-Judea Congregation. They have participated in numerous Torah study classes and have been active in the Eliztur Sports League, of which Jordan Rush was a founder.

Mr. Speaker, I ask you and my colleagues to join me in congratulating Mina and Jordan Rush for receiving the prestigious Service Award of B'nai David-Judea Congregation and in expressing appreciation for their many contributions to our community. I extend to them great thanks and wish them every happiness and success in all future endeavors.